

## **APPENDIX E**

### **NHDS Medical Abstract Form**

**Notice** – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden of this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0212)

FORM **HDS-1**  
(11-12-99)

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS COLLECTING AGENT FOR  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL CENTER FOR HEALTH STATISTICS

## MEDICAL ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

### A. PATIENT IDENTIFICATION

1. Hospital number .....	<input type="text"/>	4. Date of admission .....	Month <input type="text"/> <input type="text"/> - Day <input type="text"/> <input type="text"/> - Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. HDS number .....	<input type="text"/>	5. Date of discharge .....	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Medical record number .....	<input type="text"/>	6. Residence ZIP Code .....	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

### B. PATIENT CHARACTERISTICS

7. Date of birth	Month <input type="text"/> <input type="text"/> - Day <input type="text"/> <input type="text"/> - Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	8. Age (Complete only if date of birth not given) .....	Units <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Years <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Days
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9. Sex (Mark (X) one)	1 <input type="checkbox"/> Male	2 <input type="checkbox"/> Female	3 <input type="checkbox"/> Not stated
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10. Ethnicity (Mark (X) one)	1 <input type="checkbox"/> Hispanic or Latino	2 <input type="checkbox"/> Not Hispanic or Latino	3 <input type="checkbox"/> Not stated
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11. Race	1 <input type="checkbox"/> White	4 <input type="checkbox"/> Asian	6 <input type="checkbox"/> Other (Specify)
	2 <input type="checkbox"/> Black or African American	5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="text"/>
	3 <input type="checkbox"/> American Indian or Alaska Native	7 <input type="checkbox"/> Not stated	

12. Marital status (Mark (X) one)	1 <input type="checkbox"/> Married	3 <input type="checkbox"/> Widowed	5 <input type="checkbox"/> Separated
	2 <input type="checkbox"/> Single	4 <input type="checkbox"/> Divorced	6 <input type="checkbox"/> Not stated

13. Expected source(s) of payment	Principal (Mark one only)	Other additional sources (Mark all that apply)
1. Worker's compensation .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Medicare .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Medicaid .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Other government payments .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Blue Cross/Blue Shield .....	<input type="checkbox"/>	<input type="checkbox"/>
6. HMO/PPO .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Other private or commercial insurance .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Self pay .....	<input type="checkbox"/>	<input type="checkbox"/>
9. No charge .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Other (Specify)	<input type="text"/>	<input type="checkbox"/>

☐ No source of payment indicated

14. Status/Disposition of patient (Mark (X) appropriate box(es))	Status	Disposition
	1 <input type="checkbox"/> Alive	a. <input type="checkbox"/> Routine discharge/discharged home b. <input type="checkbox"/> Left against medical advice c. <input type="checkbox"/> Discharged, transferred to another short-term hospital d. <input type="checkbox"/> Discharged, transferred to long-term care institution e. <input type="checkbox"/> Other disposition/not stated
	2 <input type="checkbox"/> Died	
	3 <input type="checkbox"/> Status not stated	

(Over)



**C. FINAL DIAGNOSES (including E-code diagnoses) (ICD-9-CM codes may be entered if no narrative is available)**

Principal: \_\_\_\_\_

Other/additional: \_\_\_\_\_

**D. SURGICAL AND DIAGNOSTIC PROCEDURES (ICD-9-CM codes may be entered if no narrative is available)**

Date of procedure(s)

Month

Day

Year

Principal: \_\_\_\_\_

Other/additional: \_\_\_\_\_

☐ NONE

Completed by

Date